

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$440.00 for date of service 1-30-01.
- b. The request was received on 1-11-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. Response to a Request for Dispute Resolution
 - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 5-28-02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 5-29-02. The response from the insurance carrier was received in the Division on 6-11-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: letter dated 1-7-02:

“On 1-30-01, Dr. provided professional anesthesia services to claimant...we were denied for our services stating code ‘N-BASE UNITS OF THE CPT CODE BILLED DOES NOT MEET THE CRITERIA FOR THE SERVICE RENDERED.’ We believe that this claim **does** warrant additional reimbursement for medical services according to

the Anesthesia Ground Rules. This patent's [sic] necessity for sedation was established and accepted...".

2. Respondent: letter dated 5-11-02:

"THE CARRIER PAID THESE SERVICES BASED ON THE **TWCC PROBLEM SOLVER**...THE CARRIER PAID THE PROVIDER BASED ON TIME UNITS ONLY. SINCE THE PROCEDURE WAS NOT INVASIVE...PAYMENT WAS MADE FOR 2 UNITS OF TIME FOR \$80.00 ON 6/2/01 – THE PROVIDER REBILLED, AND ON 1/26/02, AN ADDITIONAL \$40.00 WAS PAID FOR THE ADDITIONAL UNIT ALLOWED BY THE PHYSICAL STATUS 'P3'."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 1-30-01.
2. The Carrier denied the disputed services as reflected on the EOB as "F – REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO STATE FEE GUIDELINES AND/OR STATE RULES AND REGULATIONS"; "N ANESTHESIA PROVIDED FOR A SURFACE PROCEDURE WILL BE REIMBURSED FOR UNITS BASED ON TIME, PHYSICAL STATUS AND QUALIFYING CIRCUMSTANCES." "N – BASE UNITS OF THE CPT CODE BILLED DOES NOT MEET THE CRITERIA FOR THE SERVICES RENDERED."
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
1-30-01	00600	\$975.00	\$80.00	N, F	\$40.00 per unit	MFG; General Instructions (I) (B); Descriptor	<p>The Carrier has denied the charges in dispute as "N, and F". Therefore, the Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.</p> <p>The Medical Fee Guideline states that reimbursement for services is dependent on the accuracy of the coding and documentation. In review of the Anesthesia Report, the provider billed for MAC anesthesia. However, the documentation on the report shows that IV sedation was used and not general anesthesia. The airway utilized was "Nasal cannula". This does not support the billing of MAC anesthesia.</p> <p>Therefore, documentation does not support the service as billed. No additional reimbursement is recommended.</p>
Totals		\$975.00	\$80.00				The Requestor not entitled to additional reimbursement .

The above Findings and Decision are hereby issued this 5th day of August, 2002.

Lesia Lenart, RN.
 Medical Dispute Resolution Officer
 Medical Review Division

LL/II

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.